STATE OF VERMONT
AGENCY OF HUMAN SERVICES

P A T H

Department of Prevention, Assistance, Transition & Health Access

B U L L E T I N N O. 00-14F

FROM Eileen I. Elliott, Commissioner for the Secretary

DATE 6/26/2000

SUBJECT General Assistance, ANFC-Emergency Assistance, Medicaid, Dr. Dynasaur, VHAP (Uninsured), and VHAP-Pharmacy

CHANGES ADOPTED EFFECTIVE 7/1 /00

INSTRUCTIONS

X **Maintain Manual - See instructions below.**

____ **Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance Bulletin**

___ **Information or Instructions - Retain until ___**

MANUAL REFERENCE(S)

2813.2 3303.3
2813.3 M813
2613.2 M102.1
4001.91

This bulletin changes policy and payment levels in General Assistance, ANFC-Emergency Assistance, Medicaid, Dr. Dynasaur, VHAP (Uninsured), and VHAP-Pharmacy. The fiscal year 2001 budget act for the support of government, Act 152 as enacted by the General Assembly, requires these changes to policy and payment levels. The budget also authorizes the filing of this bulletin using an expedited rulemaking process. In response to the expressed concern and with the approval of the Joint Legislative Committee on Administrative Rules, the department has withdrawn sections 3400 through 3405 relating to the creation of the proposed VHAP Pharmacy Discount program, from this bulletin. The proposed changes are summarized below.

General Assistance/ANFC-Emergency Assistance for Temporary Housing

The budget act increases the maximum number of days temporary housing assistance may be granted from 28 to 84 in any consecutive 12-month period. The budget act authorizes an amount not to exceed $150,000 for the purpose of granting such temporary housing assistance for an additional 56 cumulative days beyond the current 28-day maximum. Assistance under this provision is not an entitlement, and shall cease upon expenditure of these allocated funds.

ANFC-Emergency Assistance for Mortgage Arrearage

The budget act increases the number of months for which rent or mortgage arrearage assistance may be granted from two to three months for families with good cause for nonpayment and from one to two months for families without good cause.

Changes in Medicaid Cost-Sharing for Beneficiaries Whose Household Income Exceeds 185 Percent of the Federal Poverty Level

The budget act increases program fees for beneficiaries whose household income exceeds 185 percent of the federal poverty level (FPL). For beneficiaries whose household income exceeds 185 percent of the FPL and is less than or equal to 225 percent of the FPL, the program fee increases from $10 to $20 per month. The program fee increases from $12 to $24 per month for beneficiaries with other health insurance whose household income is more than 225 percent of the FPL but not more than 300 percent of the FPL. For beneficiaries without other health insurance whose household income is more than 225 percent of the FPL but not more than 300 percent of the FPL, the program fee increases from $25 to $50 per month. The monthly program fees for these three groups of beneficiaries are paid on a quarterly basis, after each three months of coverage. The budget act authorizes these program changes subject to approval by the Health Care Financing Administration.

Changes in VHAP (Uninsured) Cost-Sharing for Beneficiaries Whose Household Income Equals or Exceeds 100 Percent of the Federal Poverty Level

The budget act increases program fees for beneficiaries whose household income equals or exceeds 100 percent of the FPL. The program fee for beneficiaries whose household income is equal to 100 percent of the FPL but is less than 150 percent of the FPL increases from $20 to $40 per six-month period, paid on a semi-annual basis. The program fee for beneficiaries whose household income exceeds 150 percent of the FPL but is less than 185 percent of the FPL increases from $25 to $50 per six-month period, paid on a semi-annual basis. In addition, the budget act requires payment of outstanding program fees as a condition of eligibility. These program changes are subject to approval by the Health Care Financing Administration.

Changes in Pharmacy Reimbursement for Medicaid, VHAP (Uninsured) and VHAP-Pharmacy

The budget act modifies the current pharmacy reimbursement rate from 90 percent of the Average Wholesale Price (AWP less 10 percent) to 88.1 percent of the Average Wholesale Price (AWP less 11.9 percent).

Addition of the Vermont Health Access Plan Pharmacy Discount Program

In response to the expressed concern and with the approval of the Joint Legislative Committee on Administrative Rules, the department has withdrawn sections 3400 through 3405 from this bulletin.

Specific Changes to Policy Pages

2613.2 Increases the maximum number of days temporary housing assistance may be granted from 28 days to 84 days.

Since the issuance of the draft rule, the department modified this section to clarify that the additional 56 cumulative days of temporary housing assistance beyond the current 28-day maximum is not an entitlement, and shall cease upon expenditure of the funds allocated for this purpose.

2813.2 Increases the maximum number of days temporary housing assistance may be granted from 28 days to 84 days.

Since the issuance of the draft rule, the department modified this section to clarify that the additional 56 cumulative days of temporary housing assistance beyond the current 28-day maximum is not an entitlement, and shall cease upon expenditure of the funds allocated for this purpose.

2813.3 Increases the number of months for which rent or mortgage arrearage assistance may be granted from two to three months for families with good cause for nonpayment and from one to two months for families without good cause.

M102.1 Increases program fees for beneficiaries whose household income equals or exceeds 185 percent of the FPL; this change is subject to approval by the Health Care Financing Administration.

Since the issuance of the draft rule, the requirement that the "any program fees due must be paid in order to be determined eligible" has been deleted.

M813 Amends pharmacy reimbursement rates.

Since the issuance of the draft rule, the pharmacy reimbursement rate has been amended as specified the policy at 3303.3

3303.3 Amends pharmacy reimbursement rates.

3400 to 3403.3 Creates the VHAP-Pharmacy Discount Plan; implementation is subject to approval by the Health Care Financing Administration.

In response to the expressed concern and with the approval of the Joint Legislative Committee on Administrative Rules, the department has withdrawn sections 3400 through 3405 from this bulletin.

4001.91 Increases program fees for beneficiaries whose household income equals or exceeds 100 percent of the FPL and requires payment of outstanding program fees to maintain program eligibility; both changes are subject to approval by the Health Care Financing Administration. Changes "premium" to "program fee" in policy.

Since the issuance of the draft rule, the required payment of outstanding program fees to maintain program eligibility has been clarified.

Since the issuance of the draft rule, the department has made other changes to clarify or correct language without changing the meaning or intent of the proposed policy.

Expedited Rulemaking Process

The Vermont legislature has enacted the fiscal year 2001 budget bill, Act 152 of 2000, for the support of government, which permits an expedited rulemaking process for these changes. The act requires notice of a draft rule, published in the three Vermont daily newspapers of highest average circulation; a seven-day public comment period; a final proposed rule to be reviewed by the legislative committee on administrative rules no later than June 22, 2000; and a final adopted rule to be filed no later than June 26, 2000. The final adopted rule has a July 1, 2000, effective date.

Summary of Written Comments and the Department's Responses

Notice of rulemaking was published on May 25, 2000, in the following newspapers: *The Burlington Free Press*, the Barre-Montpelier *Times-Argus*, and *The Rutland Herald.*

Five persons submitted written comments on behalf of the Office of Health Care Ombudsman, the Vermont Coalition for Disability Rights, the Community of Vermont Elders, the Vermont Low Income Advocacy Council, and the National Association of Chain Drug Stores.

The written comments and the department's responses to them are summarized below.

The responses below do not reflect changes made to these policies after the filing of the final proposed rule with the Legislative Committee on Administrative Rules.

Changes to Increase Temporary Housing Assistance

Comment: One commenter suggested that the proposed rule to increase the limit for temporary housing assistance from the current 28-day maximum to an 84-day maximum does not appear to restrict the $150,000 allocated in the budget act to providing such assistance beyond the current 28-day maximum.

Response: The department agrees that the intent of the budget act is to use the $150,000 allocation exclusively for temporary housing assistance beyond the current 28-day maximum. The department will track expenditures to assure that the $150,000 will be used only for the additional 56 cumulative days of temporary housing assistance beyond the current 28-day maximum.

Increase in the AABD State Supplement to SSI

Comment: Two commenters questioned why the increase in the AABD state supplement authorized by the budget act is not included in the expedited rule.

Response: The department will implement the AABD increase in a procedures bulletin.

Changes in Medicaid Cost-Sharing for Beneficiaries Whose Household Income Exceeds 185 Percent of the Federal Poverty Level

M102.1 Program Fees

Comment: Two commenters noted that the sentence "Any program fees due must be paid in order to be determined eligible" was unclear and requested that it be clarified. One commenter asserted that the sentence was a new requirement and was not authorized by the language in the Budget Act.

Response: The department agrees and has deleted the sentence.

Changes in Pharmacy Reimbursement for Medicaid, VHAP (Uninsured) and VHAP-Pharmacy

M813 and 3303 Price of Ingredients

Comment: One commenter objected to the proposed pharmacy reimbursement asserting the pharmacy reimbursement level is not the cause of increasing state Medicaid prescription drug costs. This commenter also asserted that the decrease in the pharmacy reimbursement rate will do little to create the savings needed in the state Medicaid prescription drug program.

Response: The budget act requires the department to reduce state expenditures by $517,640 with the expectation that the department would modify its payment formula for pharmaceuticals to achieve these savings. The rule proposes to change the payment formula from AWP minus 10 percent to AWP minus 11.9 percent to meet this requirement. The department's current payment formula for drugs is in excess of rates paid by large private sector payors. The department agrees that a number of factors are contributing to pharmacy expenditure increases.

Addition of the Vermont Health Access Plan Pharmacy Discount Program

3400 Introduction

Comment: One commenter stated that implementation of VHAP-PDP would impose price controls on community pharmacies because the program requires community pharmacies to charge the Medicaid reimbursement rate to Medicare beneficiaries with incomes below 300 percent of poverty.

Response: The rates paid under the VHAP-PDP program will be the rates paid under the Vermont Medicaid program. Medicaid rates are not price controls because Medicaid rates are established independently, and do not control the rates paid by individuals, insurers or other third parties that pay for pharmaceuticals.

Comment: One commenter observed that the policy for VHAP-PDP does not give a specific start date, noting that the program will become effective as soon as administratively possible, following approval by HCFA. Two commenters suggested that the department issue a

PP & D when the program goes into effect.

Response: The rule does not specify a start date for VHAP-PDP because implementation of this program is contingent on approval by HCFA. Implementation will also require system modifications. The department will notify the public and issue a PP & D when this program becomes effective.

Comment: One commenter requested the establishment of an administrative system that would inform the pharmacy of a customer's eligibility for the discounted price and identify the price to be changed by the pharmacy.

Response: Beneficiaries of VHAP-PDP will be identified by a unique category code. The amount due from the beneficiary will be set electronically at the point of sale when the pharmacy enters the claim in the electronic claims processing system.

Comment: One commenter asserted that the department should compensate pharmacies for the rebate discount in a timely manner, preferably within two weeks of the date the pharmacy submits the claim.

Response: The department will issue the VHAP-PDP rebate to pharmacies in the usual manner for processing any pharmacy claim.

3401 Eligibility

Comment: One commenter asserted that for individuals with Medicare eligibility, VHAP-PDP is only "precluded if [beneficiaries] have Medigap that covers prescriptions" and that the use of "insurance policy" is inconsistent with the language of the budget act. Another commenter stated that VScript should not be considered an "insurance policy' or "insurance program" when determining eligibility for VHAP-PDP.

Response: The department agrees with the commenters and has revised policy to clarify these points. In addition, the department has specified in 3401.1 that individuals covered by VScript are considered uninsured for drugs excluded from coverage in 3202.1.

Comment: One commenter stated that VHAP-PDP coverage for VHAP beneficiaries should be clarified.

Response: The department has clarified the coverage for VHAP beneficiaries in 3400 and 3401.1.

3402 Eligibility Process

Comment: One commenter requested clarification that VHAP-PDP beneficiaries may apply for other health care programs at any time.

Response: The department agrees with the commenter and has adopted the suggestion.

Comment: One commenter requested integration of the VHAP-PDP application with the applications for other programs so that applicants and beneficiaries need only to complete one application to receive benefits. Another commenter supported this approach, requesting that an application for VHAP-PDP be considered a preliminary application for Medicaid. This commenter asserted that the department should review such an application for the highest level of eligibility as long as additional information needed for a determination of Medicaid eligibility is provided.

Response: The VHAP-PDP, if approved by the Health Care Financing Administration, will be a program operated under the provisions of Vermont's 1115 (a) research and demonstration waiver. As such it is not an entitlement. Administrative costs must be met by the program's annual fee. Linking VHAP-PDP to other programs requires extensive eligibility systems programming, which would have to be reflected in the annual fee. In addition, the amount of information required from a VHAP-PDP applicant will be minimal, making an integrated application process impractical. Legislative testimony from the Administration indicated that this would be a stand-alone program.

Beneficiaries eligible for VScript will be found automatically eligible for VHAP-PDP.

Comment: Two commenters requested inclusion of VHAP-PDP applications in Vermont income tax booklets with the other state pharmacy program applications.

Response: The department agrees with commenters that VHAP-PDP applications be available in Vermont income tax booklets. The department intends to have the VHAP-PDP application included for the tax year after this program is approved by HCFA, providing the publication deadline allows it.

3402.3 Period of Eligibility

Comment: One commenter asked what the program review frequency was for beneficiaries in VHAP-PDP.

Response: The department has added this information. Once found eligible for VHAP-PDP, beneficiaries with Medicare will remain eligible for the pharmacy discount program with no review requirement unless their circumstances change. Beneficiaries with incomes not exceeding 300 percent of the FPL will have their program eligibility reviewed annually.

Comment: One commenter requested that the department clarify the policy to ensure that the expanded VScript beneficiaries are not excluded from this program. Another commenter requested that "insurance policy" be changed to "Medigap".

Response: The department clarified policy (3400 and 3401.1) by specifying beneficiaries from other VHAP waiver programs that may be eligible for VHAP-PDP. In addition, the department has changed "insurance policy" to "Medigap" where applicable.

3402.5 (formerly) Application for Other Benefits

Comment: One commenter asked the department to explain how it will coordinate VHAP-PDP and VScript benefits.

Response: The department clarified in 3401 that VScript beneficiaries will be eligible for VHAP-PDP for prescriptions not covered by VScript. If VScript beneficiaries seek to have a prescription filled for an acute care drug, they will get the discount available under VHAP-PDP; for maintenance drugs, the beneficiary will get the benefit available under VScript with the required co-payment.

3403.1 (formerly) Cost-Sharing

Comment: One commenter suggested changing Cost Sharing to Program Benefit because the term cost sharing usually describes a beneficiary's cost rather than a reduction of the prescription cost gained through VHAP-PDP.

Response: The department agrees with the commenter and has changed the heading from Cost Sharing to Program Benefit.

Comment: One commenter asserted that the section was confusing and suggested a clarification.

Response: The department has clarified the section.

Comment: One commenter asserted that the policy is not clear as to whether the rebate amount will be the same for VScript beneficiaries who pay 50 percent of their maintenance drug costs or whether they will receive only half of the reduction from the rebate. In addition, this commenter believed that if the VScript beneficiaries receive a lesser discount amount, then their enrollment fee should be reduced.

Response: For VScript beneficiaries, the discount will apply only to acute care drugs. The subsidy for VScript beneficiaries for maintenance drugs is at least 50 percent, which is greater than the discount provided by VHAP-PDP. The enrollment fee for VHAP-PDP will be collected at the point of use of the benefit, and will thus be affected by a VScript beneficiary's use of drugs for acute conditions.

3403.2 Enrollment Fee

Comment: One commenter believed that at the time of initial enrollment that beneficiaries would be required to pay a one-time enrollment fee.

Response: The budget act specifies that "An annual enrollment fee, established by rule is authorized." The intent of the enrollment fee is to cover the initial and ongoing administrative costs of the program. Without the annual fee, as specified in the budget act, the department would be unable to administer the pharmacy discount program without an appropriation.

Comment: One commenter stated that the fees of $20 for calendar years 2000 and 2001 seem high in relation to fees for other programs which provide far greater benefits and in relation to the costs to the department for implementing this program. This commenter believed that the fee for 2000 and 2001 should be combined into one fee amount. In addition, the commenter stated that the rule did not provide for a reduction of the enrollment fee in calendar year 2001, if the program starts after January of that year. A commenter asserted that the requirement of an annual enrollment fee from each individual is unusual and significantly undercuts the legislative intent of the program to provide financial help for households experiencing high prescription drug costs.

Response: Enrollment fees are intended to cover the expenses associated with administration of the program. The fee has been set at a rate that covers these projected expenses and is not linked to the scope of benefits received by beneficiaries. A methodology which establishes a fixed dollar amount per prescription for a fixed number of prescriptions offers the benefit of being more easily understood by program enrollees. However, under a fixed-rate approach, a larger percentage of program enrollees will pay less than the full enrollment fee. As a result, it becomes necessary to raise the maximum enrollment fee from $20.00 to $24.00 in order to ensure revenues sufficient to cover administrative costs.

Depending upon when this program is approved, the annual enrollment fee for VHAP-PDP may be adjusted if necessary.

The fee will be collected as prescriptions are filled and, if implementation begins late in 2001, it is unlikely that the benefit would be used sufficiently to collect the full fee. The department has changed the proposed method from a percentage of cost to a flat rate of $3.00 per prescription. In order to realize sufficient revenue, the annual maximum will be $24.

Comment: One commenter stated that VHAP-PDP policy should consistently contain all criteria and requirements specific to the program and should not refer to regulations governing other programs. This commenter asserted that simply referring to regulations was problematic for people accessing VHAP-PDP regulations because of the references to other programs and not all of the regulations are updated or have the necessary information. Another commenter requested the VHAP regulations to be reprinted in VHAP-PDP policy.

Response: The sections of VHAP policy that were referred to in VHAP-PDP policy are quite uniform for our healthcare programs: citizenship, income, application decision, and notice and right to appeal and were not reprinted in VHAP-PDP policy to be more administratively efficient.

Comment: One commenter requested that the department put in better assurances to prevent those who have paid their annual enrollment fees from unwarranted removal of coverage.

Response: Since the annual enrollment fee will be paid only when the benefit is used, no other protections are needed.

Comment: One commenter supported the department's proposal to collect the annual enrollment fee when the beneficiary fills prescriptions but stated that the method of fee collection was confusing for the beneficiary and suggested three alternate ways of fee collection.

Response: The department will collect the enrollment fee in a fixed amount of $3.00 per prescription or refill until such time as the fee of $24 has been paid. After 8 prescriptions or refills, the annual enrollment fee will be paid. Beneficiaries can keep count of their fee based on a count of the prescriptions that have been filled.

3405 Benefit Coverage

Comment: One commenter asserted that refills beyond the original prescription and five refills of that prescription within one year was a restriction for beneficiaries that is not supported by the budget act. This commenter expressed concern that the department may require beneficiaries to fill prescriptions for 90-day periods and cause them significant financial hardship. Another commenter requested that the department clearly state that VHAP-PDP does not require the purchase of a 90-day supply of medication.

Response: The purpose of limiting refills to five in a year is to ensure that a patient's condition and need for the prescription is monitored and evaluated by their physician. If the physician writes another prescription for the medication following that evaluation, it will be filled. The department does not intend to require purchase of prescriptions by VHAP-PDP beneficiaries in 90-day supplies.

Changes in VHAP (Uninsured) Cost-Sharing for Beneficiaries Whose Household Income Equals or Exceeds 100 Percent of the Federal Poverty Level

4001.91 Program Fee

Comment: One commenter requested the language regarding payment of program fees be clarified and for the department to define "outstanding" program fees.

Response: The department has clarified this section.

Comment: One commenter stated that VHAP beneficiaries should not be required to pay the full program fee in an entire six-month period in which they may have only been covered for a portion of the prior period before becoming eligible for a new six-month period, and liable for a new program fee. Another commenter stated the policy should be drafted to prevent individuals from being expected to pay for coverage during a period of ineligibility because the fees would be excessive.

Response: The department agrees. VHAP beneficiaries will only be required to pay program fees due for the prior periods of coverage.

Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing regulation content.

Manual Maintenance:

MANUAL HOLDERS: Please maintain manuals assigned to you as follows.
You will need both the proposed and the final bulletin to maintain
Your manuals

Remove		Insert	
		Medicaid Policy	
M102.1	(99-15F)	M102.1	(00-14)
M813	(91-31)	M813	(00-14)
		WAM Manual	
2613.2	(95-5F)	2613.2	(00-14)
2813.2	(87-26)	2813.2	(00-14)
2813.3	(98-21)	2813.3	(00-14)
3303.1 P.2	(96-4F)	3303.1 P.2	(00-14)
4001.91	(98-23F)	4001.91	(00-14)